Behavior Change Communication for Better Health Outcomes in Africa

Experience and Lessons Learned from World Bank-Financed Health, Nutrition and Population Projects

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Table of Contents

Acknowledgements ................................................................. v
Foreword ..................................................................................... vii
Abbreviations and Acronyms ......................................................... viii
Introduction ................................................................................ 1
The Role of the Bank in Behavior Change Communication .................... 11
   in Bank-financed HNP Operations

Annexes

1 Behavior Change Communication Activities Executed under ............... 15
   World Bank Africa Region HNP Operations

2 Implementation Completion Report Questionnaire Responses .............. 23

3 Selected Resources for Strategic Communication .............................. 25

4 A Case Study of Behavior Change Communication: .......................... 27
   The Uganda Nutrition and Early Childhood Development Project
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The present study addresses a topic—using strategic communication to achieve better health outcomes—that is critical to achievement of the Bank’s corporate goals in Africa, including especially the Millennium Development Goals. Yet, the evidence in the study suggests that, despite acceptance of communication as a legitimate and appropriate project component, behavior change and behavior change communication have failed to receive the attention they merit in Bank health, nutrition, and population (HNP) operations. This does not mean that task managers must become specialists in communication. Indeed, there may be risks for task managers in endeavoring to sponsor and support behavior change programs without the injection of technical expertise on communication and associated social research. The evidence in the study suggests that there are sufficient technical resources available, inside and outside the Bank, for those who would draw upon them. Partnerships are shown to be an important element of successful communication programs.

The study suggests that communication should be an essential element of the management of all Bank-financed HNP operations, whether they support disease control or health reform. The failure of the Bank to deploy strategic communication to support health reform projects Africa is a striking gap identified in the study.

The proposals set out in the paper—if implemented—will contribute to achievement of the approach set out in the Africa Region Strategic Options study. Thus, I commend the study to Bank HNP staff, and our external partners as well.

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Abbreviations and Acronyms

AIDS  Acquired Immune Deficiency Syndrome
APL   Adaptable Program Loan
BCC   Behavior Change Communication
DHS   Demographic and Health Surveys
EPI   Expanded Program of Immunization
FAO   Food and Agricultural Organization of the United Nations
FP    Family Planning
GTZ   German Technical Assistance Agency
HIV   Human Immunodeficiency Virus
HNP   Health, Nutrition and Population
ICR   Implementation Completion Report
IEC   Information, Education, and Communication
MAP   Multi-Country Assistance Program (for AIDS)
MCH   Maternal and Child Health
MOH   Ministry of Health
NGO   Non-Governmental Organization
OED   Operations Evaluation Department
PAD   Project Appraisal Document
PHN   Population, Health, and Nutrition
PPAR  Project Performance Audit Report (OED)
STD   Sexually Transmitted Disease
STI   Sexually Transmitted Infection
SWAp  Sector-Wide Approach
TB    Tuberculosis
UNFPA United Nations Population Fund
USAID United States Agency for International Development
Behavior change has moved to center stage in the work of African governments and their domestic and international partners to improve health outcomes. Households and communities are increasingly recognized as key actors and subjects, not merely objects, in the struggle for better health. Identification of their wants and needs, and the translation of their needs to effective demand, requires sound communication strategies. Within the World Bank, the Africa Region’s recently published study of strategic options for the Bank in dealing with health, nutrition and population in Africa stresses the lack of effective demand by beneficiary populations as one of the greatest challenges to increasing coverage of African countries with cost-effective health interventions.2 The lack of effective curative care interventions for HIV/AIDS reinforces the critical importance of behavior change to prevent infection, and contributes to the increasingly central position of behavior change communication in efforts for health improvement. Finally, the growing emphasis on development results, within the World Bank and the larger international development community, reinforces concerns with behavior change in target populations of beneficiaries and service providers.

Effecting sustainable changes in health behavior is an enormous challenge. It requires deep knowledge of local cultures, of the values and attitudes that motivate health-related behaviors, and of the dynamics of interactions at the household level. It also calls for a high level of personal modesty, by those who engage in the endeavor, and sensitivity to the ethical implications of intervening in social systems. Once these challenges have been overcome, those who would effect behavior change need to consider alternative means. The standard answer of economists is to change prices, costs, and incentives. The approach of this paper is to look instead at strategic communication as a tool to influence behavior.

The objective of the present study is to contribute to strengthening the work of the World Bank on health, nutrition and population (HNP) in Africa by distilling experience and lessons learned from behavior change communication in Bank-financed HNP investment projects in Africa. The principal audience for the paper is World Bank health, nutrition and population staff. It is hoped that the work presented herein

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may also be helpful to the Bank’s clients and its development partners.

The study covers sixty-one projects in thirty-six African countries over more than twenty years. It thus reflects changes over time in thinking and terminology among development specialists on the issues covered. From the 1950s through the 1970s the criteria for success in communication programs were largely target audience satisfaction and efficiency in use of inputs. In the 1980s leading-edge organizations started using effectiveness and outcome as success criteria, but the measurements were still focused on activities (channels and messages) and perceptions (knowledge and attitudes of target audiences). Performance-driven organizations like the Bank today increasingly strive to measure the impact of communications on changes in behavior and on organizational goals, with effectiveness and outcomes the principal success criteria.3

Until fairly recently in Bank HNP operations, communication programs were commonly labeled information, education and communication (IEC). Project components designed within an IEC framework tended to concentrate on development and dissemination of educational materials and information, seeing communication as largely unidirectional. More recently, thinking on strategic communication as a development tool has come increasingly to recognize the importance of dialogue and client perspectives in the design of health and other development interventions.4 The focus moves from concentration on IEC inputs to communication program outputs and ultimately to behavior change results. For these reasons the present paper uses a terminological convenience of labeling all strategic communication activities under Bank-financed HNP operations as behavior change communication (BCC).

Occasionally, but rarely, behavior change communications programs supported by the World Bank have been labeled health promotion. Health promotion is the term favored by the World Health Organization. WHO documents refer to preventive, curative, promotive and rehabilitative services, and WHO has a Department of Chronic Diseases and Health Promotion. The well-known Ottawa Charter on Health Promotion was initiated in 1985 at the first of a series of global WHO conferences on the subject. The 6th such WHO conference will be held in Bangkok in August 2005.

The present review is based on implementation completion reports (ICRs) and Operations Evaluation Department (OED) project performance assessment reports (PPARs) available through the end of 2002. It covers the entire set of HNP operations for which completion reports are identified in the Bank’s Imagebank database of reports5. In some cases Project Appraisal Documents were also examined. A limited number of HNP staff interviews complemented the examination of ICRs. In a few cases, to illustrate a point relevant to the African experience, the review cites the experience of other Regions and of recent Project Appraisal Documents when ICRs are not available.

The methodology chosen for the study, based on ICRs, has the advantage of being able to synthesize actual experience with Bank-supported behavior change programs, rather than only the plans set out in appraisal reports. However, the methodology led to several important weak-

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4 This is not to suggest that all thinking has moved in the new directions. A recent article, for example, argues that current practices remain based on one-way models of information transfer based on expert understanding. (Lee, Renee Gravois Lee and Theresa Garvin, 2003. “Moving from Information Transfer to Information Exchange in Health and Health Care,” *Social Science and Medicine* 56, pp. 449-464.)

5 One project not in the Imagebank under HNP, the Madagascar Food Security and Nutrition Project, has been added to the database, on the grounds that it is basically a nutrition operation.
nesses: First, because the study is largely limited to completion reports, it does not cover the most recent operations, and therefore fails fully to reflect the latest activities and thinking of Bank staff, nor the latest innovations in Bank lending policies and practices. For lack of resources, the study also was unable to undertake more detailed file or field research, beyond the ICRs and OED studies. Secondly, the study suffers from the inevitable softening of critical perspectives in ICRs written by staff who were often responsible for the projects during their execution. Third, because of its base in completion reports, the paper largely fails to address the new Multi-country Assistance Program (MAP) operations to combat HIV and AIDS, where BCC has assumed a much greater prominence than under the Bank’s HNP investment projects (Box 1).

The main part of the paper starts with a discussion of behavior change communication programs financed by the Bank in Africa, including their frequency and cost, content, types of project, and social research background. The paper then discusses lessons learned concerning the role of the Bank in behavior change communication for better health outcomes in Africa and some changes in perspective that would be desirable. The paper concludes with a summary of its main messages. Annexes include a compilation of BCC activities financed under Bank HNP operations in Africa, by country (Annex I), detailed results of a questionnaire administered on ICRs to collect BCC information on a consistent basis for this study (Annex II), a list of selected resources for strategic communication, with web addresses (Annex III), and a case study of BCC in the Uganda Early Childhood Development Project showing how the principles set out in this study have been applied in that project (Annex IV).
Health Behavior Change Communication Programs financed by the World Bank

BCC is quite common—indeed, more frequent than is widely surmised—but it tends to be a relatively small part of Bank HNP operations in Africa. A surprisingly high three-quarters of the projects examined as part of this review had a BCC component or, as was usually the case, a BCC sub-component or other activity recorded in the ICR. BCC costs were about eight percent of total costs, where data were recorded. However, only about half of the ICRs contained sufficiently disaggregated cost information to reveal BCC spending as a proportion of total project expenditures. Even the OED Project Performance Audit Report on the Kenya STI Project was hardly able to identify spending, reporting that with the exception of an audiovisual component over $2 million the costs and outputs of IEC activities are poorly documented. It is likely that BCC spending was substantially less than eight percent for the larger share of operations on which no BCC cost data were reported in the ICRs. For those ICRs that contained cost data, average actual BCC expenditure was $1.82 million. Usually, actual costs on BCC recorded in the ICR were somewhat less than planned spending recorded at the time of appraisal.

Despite their relatively marginal position in HNP operations, the BCC activities financed by the Bank in its HNP operations in Africa cover an impressive range of activities and projects. BCC activities financed by the Bank included mass media campaigns (radio, TV, newspapers), popular or folk media campaigns (theater, dance performances), social marketing, community mobilization, education, women’s literacy groups, and advocacy efforts. The choice of communication channel—often seen to be routine by outsiders—is critical to the success of a communication program, as can be seen in the child fairs of Uganda (Box 2). Annex 1 compiles BCC activities under Africa Region HNP operations documented in ICRs.

The Chad Population and AIDS Control Project that closed in 2001 may be cited as an example of a project with a full and quite successful range of BCC activities. The IDA Credit funded monthly radio and TV programs providing information on the National Population Policy; training of journalists, opinion leaders, women leaders, trade-unionists, and administrators on population and reproductive health; two Knowledge, Attitude and Practice (KAP) studies; a training study tour to visit a condom social marketing program in another African country; regional training in IEC; and promotion campaigns. Among other documented results, the Project succeeded in raising awareness on population issues, as documented in surveys four years apart.

BCC programs need to go beyond provision of information to target populations. Increasing levels of knowledge are usually insufficient to bring about behavior change, for individuals need to move from information to motivation to experimenting with behavior change before they can be expected fully to internalize adjustments in deeply engrained behaviors. The Burkina Faso AIDS Control Project ICR draws attention to the problem, and to the importance of channels of communication (i.e., the credibility of the ‘messenger’). ‘Demand-driven’ communications programs can be important in environments where cultural sensitivities are great, such as HIV, as shown in the Senegal Human Resources Development Project ICR.

The record of BCC experience suggests two fundamentally different types of HNP investment operations have evolved for World Bank task managers, with different approaches to BCC. Projects with a focus on one or more specific diseases or other health problems tended to have

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6 Report 25016.
7 Report No. 24344.
INTRODUCTION

the importance of attitudes of stakeholders in the success of reforms. Yet, as the experience of Moldova indicates (Box 3), the techniques of strategic communication can be extremely valuable for the health reform manager concerned to understand different perspectives and maintain widespread political and popular support for reform. Thus it is hardly surprising that communication for influencing behavior is one of the five ‘control knobs’ for implementation of health sector reform and influence health system performance in the framework of Harvard Professor William Hsiao used in the World Bank Institute’s Flagship Program on Health Sector Reform and Sustainable Financing.

Box 2

Child Fairs and the Critical Importance of Choice of Communication Channel

The communication strategy for the Nutrition and Early Childhood Development Project in Uganda elaborated on an existing but not yet widespread service delivery channel—“Child Fair”—as a key communications channel to disseminate messages related to the proper care and feeding of children. Child Fairs were family-oriented events used as fun occasions at which to vaccinate children, to provide them with vitamin A and de-worming medicines, and to demonstrate proper feeding techniques. Messages were delivered through skits, plays, demonstrations, posters, and pictographs.

A longitudinal evaluation report on the project noted Child Fairs proved to be a cost-effective channel through which to reach people with both health services and messages. Project managers spent between $500–$600 per Child Fair and reached an average of 450 children per event. The cost per child reached was about $1.00 to $1.33 for a set of services, including inoculations, growth monitoring and vitamin A supplements. They were also one of the more effective channels of communication for the delivery of messages conveyed through interpersonal contact, which is more effective than written materials and handbooks.

An evaluation of the communications activities conducted by Steadman Research Services notes: “Most dramatically, the child health days have protected inoculation rates from a decline and have contributed to increased intake of vitamin A and, where provided, de-worming medicine. At the time of the resurvey, children in the project sites had attended a child day a little less than twice in the last two years.”

BCC. The projects most likely to have a BCC activity included family planning and HIV/AIDS; the new MAP operations, while not yet covered by ICRs, represent an extreme case of this. Others likely to have a BCC activity included disease control (notably malaria, TB, STIs, and EPI) and nutrition. Nutrition projects stand out for use of BCC, because of the focus of nutrition projects on changing specific nutrition-related behaviors.

In contrast to projects with a specific disease or health problem focus, health reform operations were striking for their complete lack of BCC. This is a remarkable finding because of the importance of attitudes of stakeholders in the success of reforms. Yet, as the experience of Moldova indicates (Box 3), the techniques of strategic communication can be extremely valuable for the health reform manager concerned to understand different perspectives and maintain widespread political and popular support for reform. Thus it is hardly surprising that communication for influencing behavior is one of the five ‘control knobs’ for implementation of health sector reform and influence health system performance in the framework of Harvard Professor William Hsiao used in the World Bank Institute’s Flagship Program on Health Sector Reform and Sustainable Financing.
The review of Africa Region ICRs was able only to document five cases where strategic communication techniques were used broadly to understand client perspectives and build consensus.

- The Gambia Women in Development Project ICR reports that the BCC interventions led to a “heightened and dynamic national debate and rethinking of the role, status, and plight of women.” New discussions on national TV, radio, and in mosques were reported to have focused on gender issues as a result.
- The Kenya Sexually Transmitted Infections Project sponsored a series of meetings and workshops to engage political leaders and civil society in discussion on HIV/AIDS. A symposium was financed in 1999 at Mombasa. 98% of the Parliamentarians and the President of Kenya attended. Interviews by OED “widely agreed” that the environment for HIV/AIDS activities improved as a result.
- The Lesotho Second PHN Project raised the level of awareness about family planning and population policy. The project held workshops for national leaders to develop consensus in regard to population policy. According to the ICR, the policy report produced was an achievement in a country where family planning was “foreign and socially unacceptable.”
- The Madagascar Food Security and Nutrition (SECALINE) Project sponsored a national IEC campaign to communicate project objectives. The project became so well known that its acronym has become a household word. The project received enthusiastic support of the country’s political leaders, who presented the project as a Malagasy initiative and not as a project financed by the World Bank.
- The Senegal Community Nutrition Project built consensus starting at the local level, by holding informative meetings every month between managers of nutrition centers, supervisors, and the community. Social mobilization sessions were held approximately every two months to inform the community on progress. The ICR states that this method of community involvement and investment proved “to be extremely effective.”

The idea of using strategic communication to understand client perspectives and build consensus is beginning to gain greater currency in the Bank’s HNP work in Africa and in other Regions. The Project Appraisal Document (PAD) for the Tanzania Health Sector Development Program, for example, mentions among the critical risks that opposition from special interest groups or politicians would undermine or block hospital reform. To mitigate this risk, the PAD foresees an ‘IEC campaign and continuous consultations to build consensus and air stakeholders’ concerns.’8 Similarly, in the 1999 Adaptable Program Loan to Peru to support the first phase of the country’s health reform program, the PAD foresees not only behavior change communication activities to change patterns of behavior in the population and to promote healthy living but also a multi-media social communication strategy to promote the country’s maternal and child health insurance program as a strategy to reduce infant and maternal mortality rates as well as the right of the beneficiaries to have permanent access to MCH services. The Peru PAD also anticipates that the project would involve participation of the civil society in building of a national consensus for the expansion of the MCH insurance scheme and for making continuous improvement of MCH services a national priority.9

The evidence assembled in the ICRs suggests that the wide range of BCC activities was normally accompanied by relatively low depth of research, data collection, and analysis. The problem extends through all phases of the project cycle and

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the complete logical chain of BCC from formative research through monitoring and evaluation of actual behavior change. Not surprisingly, projects that undertook intensive planning prior to credit approval were more likely than others to have measurable indicators in the ICR. These projects usually had indicators to measure BCC inputs and outputs; a few measured the impact of BCC on health behaviors. Detailed program planning, however, was not necessarily associated with more successful and effective BCC activities. The data do indicate, at least, that projects with minimal planning were more likely to have little or no information in the ICR regarding output or impact measures.

Only six of the projects (13% of those with BCC) had indicators that measured BCC inputs and also achieved substantial progress in reaching their established goals. In seven of the projects, only partial progress was achieved in producing desired inputs. There was one project that was only able to achieve negligible progress towards indicators. The remaining thirty-three projects—nearly three-quarters—did not have any indicators in the ICR that were used to measure BCC inputs. This is an indication of the extent to which BCC has generally been regarded as a marginal activity in African Region HNP operations.

In regard to outputs, according to the ICRs seventeen of the projects (36 percent) achieved substantial progress in meeting their BCC indicators. Eight projects achieved partial progress and six achieved negligible progress in reaching established targets. The remaining sixteen projects did not have information included in the ICR that pertained to output indicators for BCC activities.

In twelve (25 percent) of the projects, the ICR reports that the BCC activity had a substantial impact and had indicators to measure BCC impact on health behaviors. In five projects, some of the BCC activities met program expectations, while others did not. Another five projects reported only negligible impact. The remaining 25 projects—a stunning 50 percent of the total—did not have indicators to measure BCC impact on health behaviors.

Box 3

Using Opinion Polling on Health Reform in Moldova

Moldova is low-income country ($460 per capita) with a small population of 4.4 million highly dependent on agriculture. Thus its experience is not irrelevant in Africa. The country’s World Bank-financed Health Investment Fund sponsored repeated random sampling of 1200 respondents on public opinion on health reform, carried out by local researchers. In general, respondents were pessimistic regarding the possibilities of the reform—56% expressed doubts or no hopes for major change. 42% said they would like to express opinions but that the authorities would not take them into account. 34% of respondents favored the health care model of industrial countries, whereas 22% wanted to return to the Soviet era model. However, public opinion was reported gradually to be inclining towards industrial country models. 44% of respondents were aware of health care reform in the initial survey, and 60% in the second survey. There were widespread fears that the money gained from closure of bankrupt hospitals would be used for purposes other than improvement of the health care system. More than half of respondents reported unofficial payments to health care providers.

Quantification of BCC results and impacts was rare in the ICRs. Occasionally, task teams associated work sponsored by the Bank with surveys undertaken by others, especially the demographic and health surveys (DHS) usually financed USAID but occasionally by the Bank. A few examples follow:

- The Botswana Family Health Project measured behavior change by the increase in the number of users of family planning and in the total fertility rate. Partly through a project-sponsored integration of family planning themes into health education programs and other activities, cities in which the project was implemented showed an increase in contraceptive prevalence rates and a decline in the total fertility rate.
- The Comoros Population and Human Resources Project supported a demographic survey after project completion that found the modern contraceptive prevalence rate had increased from three percent to eight percent.
- The Performance Audit Report for the Kenya Sexually Transmitted Infections (STI) Project found contradictory results at project completion but drew well on surveys by others. Results from DHS surveys in 1994 and 1998, and a survey of knowledge, attitudes and practices in 2001 found that “increased awareness was slow to translate into behavior change, but [the] surveys suggest a reduction of risky behavior since the mid-1990s. Condom use remains low among married couples (6 percent), but the percentage of sexually active men who have ever used a condom increased steadily from one-third in 1993 to half in 2000.”

Only two projects reported conducting an assessment of BCC impact.

a) The Zimbabwe Second Family Health Project included two operations research studies into the effectiveness of the maternal and child health education component. The results were used to assist the health education unit of the Ministry of Health to improve the quality of materials that were being produced.

b) The Burkina Faso Population & AIDS Control Project supported a DHS survey that

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10 Report No. 19522
11 Report No. 23520

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Box 4

**Measuring Results of Communication: The Beneficiary Assessment for the Multi-Country HIV/AIDS Program (MAP) in Niger**

For the MAP project in Niger, a beneficiary assessment provides an excellent example of collecting target audience impressions of AIDS-related communications:

- 46 % found them monotonous (‘We are always being presented with the same thing’)
- 23 % found them theoretical (‘They place too much emphasis on fidelity and abstinence, which are hard to adopt’)  
- 21 % found them shocking (‘AIDS equals death’, ‘AIDS is incurable’, …)
- 17% found them not well adapted (‘Pictures are foreign,’ ‘Discussions are generally in French’ ….)
- 12 % found them sterile (‘They lack testimony of Nigerien persons living with HIV’)

found increases in knowledge levels, but only modest progress in bringing about changes in sexual practices.

A results focus in BCC will require that the Bank and its clients give increasing attention to social research for achievement of behavior change and attribution of behavior change to communication interventions. The experience of the Kenya Sexually Transmitted Infections Project illustrates the difficulty of this task (Box 5).

*Experience documented in the ICRs illustrates the importance of partnerships for successful BCC work.* Successful execution of BCC activities tended to be associated with collaboration bringing together multiple governmental and/or non-governmental agencies. In forty percent of the projects, the implementation of the BCC activity involved a successful collaboration. In more than one-quarter of the projects (28%), collaboration between multiple partners was moderately successful. In eight of the projects, data were either not applicable or not documented. The ICRs suggest that two projects are notable exceptions, the Burkina Faso Population and AIDS Control Project and the Chad Population and AIDS Control Project. For the Burkina Faso Population and AIDS Control Project the ICR states that the collaboration between multiple government and non-governmental agencies was a “notable achievement.” The ICR indicates that the capacity of many local NGOs to achieve project objectives was enhanced by the support of international NGOs and smaller associations linking themselves up with umbrella NGOs. Public-private partnerships can be a particularly strong form of collaboration for successful BCC activities (Box 6).

**Box 5**

BCC Results and the Problem of Attribution: Findings from the Kenya Sexually Transmitted Infections Project Performance Audit Report (PPAR)

The PPAR carried out by the Bank’s independent Operations Evaluation Department tried to evaluate behavior change, but found that attributing changes in behavior to program interventions is difficult, even with rigorous evaluation. The report discusses influences on behavior change and concludes: “A statistical analysis of a recent knowledge, attitudes, and practices survey found that after controlling for other variables: (i) individuals exposed to ‘generic’ AIDS prevention messages in the mass media were more likely to use condoms; (ii) the likelihood of condom use increased with repeated exposure to prevention messages. Yet, an analysis of 1998 Kenya DHS results found that there was no association between receiving information from a health worker and condom use for men or women. These results ... suggest that (i) IEC activities could have contributed to awareness and behavior change, but the impact was probably reduced by inadequacies in targeting, pre-testing, and dissemination; (ii) despite training, health providers are not yet providing adequate HIV prevention education and counseling. The increased discussion of HIV/AIDS by national and local political leaders in the late-1990s probably also contributed to increased awareness, but there is no way to assess the impact on behavior.”

*Source:* Performance Audit Report, Report No. 25016

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12 Report No. 23520.
Box 6

Public-Private Partnerships for Communication Support in Early Childhood Development Projects

Glaxo Smith Kline (GSK) has partnered with the Bank to develop country capacity for communication work in Bank-financed early childhood development projects in Uganda, Eritrea and Zambia. Working in partnership with a Bank communication specialist, GSK provided a full-time communication advisor based in country for two years at no cost to the project. In Uganda, after two years of hands-on training, a Ugandan national took over the management of the communication component. An analysis of impact of the Uganda program showing positive results is summarized in Annex 4. Public-private partnerships of this type might be explored for other health-related communication programs.

The Bank’s technical support from staff or Bank consultants for behavior change activities in connection with its HNP operational missions in Africa appears to have been extremely limited. Little information was reported in the ICRs. According to fifteen project ICRs (32 percent), there was minimal input from staff or Bank consultants who were non-BCC specialists. In three projects there was no input from staff or Bank consultants during any of the supervision missions or any earlier part of the project cycle. In eleven projects, there was no data available in the documents regarding Bank supervision of the BCC activity. As recorded in the ICR, only six projects containing a BCC activity (13 percent), were fully supported by Bank supervision of this work. These data reflect also the fact that the Africa Region has only one HNP task manager with a technical professional background in behavior change communication.

Successful introduction and management of BCC in Bank-financed HNP operations calls for four changes—largely changes in perspective—by Bank staff.

The first step is to move beyond single investment projects as the unit of analysis and intervention for behavior change. Behavior change is a very long-term activity, and not something where final results can be expected and measured over the normal period of about five years of an HNP investment project. Thus, the Bank needs to move from a project approach to a program approach to behavior change. Such a shift would be fully consistent with the general trend in the Bank towards programmatic lending and, in the health sector, towards a Sector-Wide Approach (SWAp). Adaptable Program Loans (APL) can be used to facilitate behavior change. The twelve-year Guinea Population and Reproductive Health Program, for example, foresaw at design the identification and training of potential advocates in phase one, with advocacy sessions oriented towards officials and decision makers. During this phase, the PAD foresees training of communicators. In the second phase, the number of individuals and groups involved in advocacy and promotion of safer behavior are to be increased, and their knowledge of issues and behavior change is to grow. Advocacy sessions will focus at regional and prefecture levels. The third phase is foreseen as the phase of ownership for the advocacy program by cultural and opinion leaders.13

An APL is not, however, imperative. The same result can be achieved by a series of HNP investment operations, though there is always a risk that

13 Report 18397-GUI.
changes in the country or of Bank staff might lead to interruption of activities that require long-term, continuing engagement to ensure success. The Bank has been involved with reproductive health issues in Kenya starting in 1974 with very little interruption but with significant discontinuities. It is striking that the opportunity afforded by this long-term involvement for a programmatic, long-term approach was not pursued, perhaps because it was not feasible in the political and institutional climate of Kenya at the time.

The second change in perspective is to move away from an orientation towards BCC as technical assistance, with an input perspective. Instead, objectives should be formulated in results terms. The approach of technical assistance for IEC by some donors has led BCC to be perceived in some African countries as a donor-driven and unnecessary activity. If a long-term time perspective of actual behavior change is not feasible, then expected results measured in terms of attitudes should be measured and quantified. Incentives for pursuit of behavior change should, where possible, be built into the structure of lending operations. Thus, if behavior change is a key goal of an APL, specific stages of behavior change (such as measured increases in awareness or experimentation with new behaviors) could be established as triggers for appraisal of the next phase of the APL. Similarly, the Bank could experiment with disbursement of funds not against specific BCC inputs but against independently monitored progress towards BCC goals.

The third change is to view BCC as a management tool. This means seeing BCC as integral to the way projects, programs, and activities are conceived, planned, executed, monitored and evaluated, and not as separable components that are distinct and can be included or excluded at will from a project containing a myriad of disparate and sometimes unrelated activities responding to multiple constituencies. However, just because BCC is viewed as a management tool does not automatically imply that BCC should be costed and managed under the project management element of an operation.

The fourth change is to approach behavior change with an attitude of inquiry into what is poorly known and understood, rather than a perspective of accepted facts. The experience of past Bank-supported BCC activities documents the failure of the social research aspect to be given adequate attention, from design through monitoring and evaluation. A results focus makes the research element imperative.

Successful BCC work under HNP operations in Africa will require partnerships. As shown above, behavior change communication has been a relatively small part of the Bank’s HNP financing in Africa. It is likely to remain so despite the growing importance of the MAP program. The Bank cannot expect to staff itself with the level of BCC expertise required to support its projects. Task teams must therefore rely largely on partnerships and trust funds to support BCC. Bilateral donors are frequently ready to support BCC components with appropriate technical expertise. The Bank’s role should be to make sure that problems are appropriately identified, goals fixed, and required social research undertaken.

Tools are available to task managers for support to behavior change communications programs. A wide variety of training courses in strategic communication is now offered through the Development Communications Unit of the Bank’s External Relations Vice-Presidency. A list of resources is in Annex 3. The growing attention to behavior change and to strategic communication in connection with Bank operations necessitates creative management by task teams and the availability of ‘just in time’ tools and information for them, in order to ensure the application of communication and social research skills at appropriate stages. To make strategic communication acceptable to clients, it should not be marketed or categorized in project descriptions and cost estimates as IEC and particularly not as
technical assistance, since TA often has a poor reputation in the minds of clients. Using NGOs for BCC, which has become common in community nutrition projects such as the Madagascar SECALINE and in the MAP operations, might help on this. Similarly, study tours might facilitate overcoming resistance to BCC programs, by demonstrating to stakeholders the difference the BCC can make on the ground.

**Conclusion**

Behavior change communication has become an important part of the landscape of World Bank health, nutrition and population projects in Africa. The main messages of this report for future action are:

1. The techniques of communication can and should make increasing contributions to achievement of the Bank’s HNP goals, not only in connection with HNP investments but also in connection with health reform.
2. A social research focus is increasingly important for Bank-supported BCC programs, throughout the project cycle.
3. Changes in perspective by Bank staff are needed to make its BCC work more effective, to think in terms of long-term programs and not simply individual HNP investment projects, to move away from a TA focus and formulate objectives in terms of results and measurable changes in behavior, to draw upon partnerships and support from others, and to conceive of BCC as a management tool.

The growing emphasis on demand variables in Bank operations, the increasing requirements for measurement of results, and the overwhelming importance of HIV/AIDS in the Bank’s work in Africa are all likely to stimulate increasing attention to behavior change communication and particularly to the social research that underlies it. However, BCC has not had and is unlikely in the future to assume financial magnitudes that would justify recruitment of a cadre of technical specialists dedicated full time to support BCC. This makes the availability of internal and external information resources, and the will and ability of staff to draw upon this information and to work in partnership with others critical to future success.
Behavior Change Communication for Better Health Outcomes in Africa
## Annex 1

**Behavior Change Communication Activities Executed under World Bank Africa Region HNP Operations**

<table>
<thead>
<tr>
<th>Country, Project, and Disbursement Period</th>
<th>Behavior Change Activities Executed</th>
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<tbody>
<tr>
<td>Angola: Health Project 12/1993–12/1999</td>
<td>Supported AIDS/STD &amp; FP public health programs; procurement of audiovisual equipment for public info campaigns</td>
</tr>
<tr>
<td>Benin: Health Services Development Project 1/1990–3/1998</td>
<td>Strengthened the capacity of the MOH to develop &amp; manage the MCH/FP, STD/AIDS, and EPI Programs. Integrated health education efforts with ongoing preventive health programs in collaboration with UNDP.</td>
</tr>
<tr>
<td>Botswana: First Family Health Project 5/1985–1/1992 (Combined data from ICR and PAR)</td>
<td>Supported the MOH in strengthening their ability to provide health education &amp; IEC materials for urban health/FP services. Integration of FP themes in health education programs in primary &amp; secondary school curricula. FLE in schools &amp; TTCs, programs for adolescents in school clubs, &amp; improved teacher training in FLE/FP. Other activities included STD/FP programs for men in work places and poster production in the areas of MCH/FP, STD, &amp; TB.</td>
</tr>
<tr>
<td>Country, Project, and Disbursement Period</td>
<td>Behavior Change Activities Executed</td>
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<tr>
<td>Chad: Health &amp; Safe Motherhood Project 2/1995–6/2001</td>
<td>Elaboration of a national communication strategy for health. Trained two senior staff in the Division of IEC &amp; 23 trainers at the central level, 95 health personnel, and 40 social mobilizers on IEC aspects. IEC materials developed &amp; disseminated, including expanded program of immunization, malaria, HIV/AIDS, Vitamin A, &amp; FP.</td>
</tr>
<tr>
<td>Chad: Population &amp; AIDS Control Project 9/1995–12/2001</td>
<td>Disseminated population &amp; reproductive health information/messages. Trained large #s of journalists, opinion leaders, women leaders, trade unionists, &amp; administrators in IEC. Used IEC messages to assist in the social marketing of condoms.</td>
</tr>
<tr>
<td>Comoros: Health &amp; Population Project 2/1984–11/1991</td>
<td>Supported a program of demographic research and organized IEC activities in the area of population, relying on traditional communication networks i.e. mosques and markets; UNFPA/FAO IEC project launched birth spacing campaign &amp; established a Health Education Unit within the Directorate of Programming.</td>
</tr>
<tr>
<td>Congo Democratic Republic: (Zaire) National AIDS Control Program Assistance Project 5/1989–1/1994</td>
<td>Video programs, audio programs, manuals, and written materials. Project held 20 or so organized training sessions on different types of AIDS control activities for healthcare specialists and individuals belonging to high-risk groups.</td>
</tr>
<tr>
<td>Country, Project, and Disbursement Period</td>
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<tr>
<td>Gambia: Women in Development Project 2/1990–12/1997 (Combined data from ICR and PAR)</td>
<td>Strengthened the Women’s Bureau: skills, literacy, MCH, &amp; agricultural training. Theater groups, radio programs, &amp; videos; IEC campaign, including over 50 advocacy materials and new channels of communication for radio, TV, and video halls. 56 women’s groups that produce shows on social issues in local languages.</td>
</tr>
<tr>
<td>Guinea-Bissau: Social Sector Project 7/1993–6/2000</td>
<td>IEC Unit rehabilitated and equipped with computers, furniture, and other materials. Produced manuals, guides, flipcharts, and films. IEC and interpersonal communication training sessions were also held.</td>
</tr>
<tr>
<td>Country, Project, and Disbursement Period</td>
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<tr>
<td>Kenya: Fourth Population Project 9/1990–1/1999</td>
<td>Provided FP services through the expansion of IEC programs to additional govt. ministries and NGOs.</td>
</tr>
<tr>
<td>Kenya: Sexually Transmitted Infectious Project 8/1995–6/2001 (Combined data from ICR and PAR)</td>
<td>Advocacy &amp; behavior change campaigns; Produced 16 mm AIDS films, video films, and radio shows in more than 11 languages, &amp; booklets. World AIDS day celebrations including lectures, health talks, awareness campaigns, &amp; drama. Also, financed the development of an IEC strategy in health education for the MOH.</td>
</tr>
<tr>
<td>Madagascar: Food Security and Nutrition (SECaline) Project 7/1993–11/1998</td>
<td>Preparation and execution of IEC strategy and plan to support project community nutrition and food-for-work activities. BCC activities informed NGOs, decision makers, prominent people, and central and regional services about the project.</td>
</tr>
<tr>
<td>Madagascar: Health Sector Improvement Project 4/1992–12/1999</td>
<td>IEC messages formatted in posters, leaflets, audio &amp; video cassettes, TV, T-shirts etc. in 6 dialects, on malaria, STD/HIV, polio, cost recovery, mental health and blood donation; 118 IEC staff were trained.</td>
</tr>
<tr>
<td>Malawi: Second Family Health Project 3/1987–11/1993 (Combined data from ICR and PAR)</td>
<td>Developed nationwide programs for the MOI, through overseas training, surveys, production of materials, and evaluation activities. Produced flipcharts, posters on nutrition &amp; youth development. Family health messages published in free publication, radio programs, and films. PPAR Audit reports project supported the</td>
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<tr>
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<tr>
<td>Malawi: PHN Sector Credit 6/1991–12/2000</td>
<td>Ministry of Women, Children, and Social Welfare introduced health and family planning messages into functional literacy, home economics, &amp; other women’s programs. The Ministry of Youth, Sports, &amp; Culture initiated FP programs targeted at youth. Sponsored radio programs, the procurement of IEC vehicles and bicycles; rehabilitation of the IEC Unit; produced videos, TV spots, comics, magazines, and brochures. The project held three regional empowerment workshops and five training sessions on skill development, including an IEC nutrition workshop and M&amp;E of IEC program seminar. The IEC component was reported to have ‘contributed positively to the strengthening of the delivery of key health messages.’</td>
</tr>
<tr>
<td>Mauritania: Health and Population Project 6/1992–1/1999</td>
<td>Developed a global strategy for health education. Equipped and provided the Ministry of Health and Social Affairs IEC Service with office space and substantial technical support. Financed health education materials and services, and provided inter-personal, radio and TV communications support.</td>
</tr>
<tr>
<td>Niger: Population Project 12/1992–4/1998</td>
<td>IEC training &amp; equipment were provided to the department of health education within the MOPH. Local level social workers were trained in interpersonal communication. Village level listening clubs and women groups were trained in literacy/micro-fund projects. Produced radio/TV messages and printed materials.</td>
</tr>
<tr>
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<tr>
<td>Nigeria: Essential Drugs Project 9/1990–6/1997</td>
<td>Supported the Health Education Branch (HEB) of the MOH, MOE, and MOI. Promoted FP messages through health education, primary education and public awareness campaigns. Supported overseas training courses in IEC. PPAR reports that HEB received some printing, photographic, and audio-visual equipment. Work on education newsletter and messages for traditional folk media partially accomplished.</td>
</tr>
<tr>
<td>Senegal: Human Resources Development Project I 1/1992–9/1997</td>
<td>Female focused IEC training in FP – had a significant impact; also, training for youth associations, health committees, pharmacies &amp; health personnel in private firms. Worked in collaboration with USAID &amp; UNICEF on parallel projects doing IEC/FP training. Project found that including gender focused-IEC in a multi-sectoral project was extremely effective, esp. supported by local-level income generating and literacy activities.</td>
</tr>
<tr>
<td>Senegal: Community Nutrition Project 12/1995–6/2000</td>
<td>Weekly IEC sessions, individual counseling, and mass media campaigns for nutrition and hygiene. Informative meetings were held each month between the managers of the nutrition centers, the supervisors of the centers, and the community; social mobilizations were held approximately every 2 months to inform community of progress with project, and this was reported to be extremely effective.</td>
</tr>
<tr>
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</tr>
<tr>
<td>Uganda: First Health Project 1/1989–9/1996 (Combined data from ICR and PAR)</td>
<td>Strengthened the Health Information Unit in the MOH; procured four mobile cinema vans for mass communication activities; and produced health messages through drama, radio, TV, newspapers, and other media. Provided training to journalists &amp; educators and supported health materials for the National Resistance Army.</td>
</tr>
<tr>
<td>Uganda: Program for Alleviation of Poverty and Social Cost of Adjustment 2/1990–9/1996 (Data from PAR only)</td>
<td>Implemented a health education program and mobilized communities to improve water systems through radio programs, plays, and workshops.</td>
</tr>
<tr>
<td>Zimbabwe: Family Health Project 6/1986–9/1993</td>
<td>Funded health &amp; FP messages for the ZNFPC (Zimbabwe National FP Council) IEC Unit &amp; the Health Education Unit of the MOH. Construction of an audiovisual &amp; graphics production facility, procurement of audiovisual equipment, materials, and training for MOH Staff. TA and funding help from GTZ.</td>
</tr>
</tbody>
</table>

14 Loan/credit effectiveness to final disbursement.
15 Source: Except as indicated, data are taken from Implementation Completion Reports finished through the end of 2002.
Behavior Change Communication for Better Health Outcomes in Africa
Annex 2

Implementation Completion Report
Questionnaire Responses

Total Number of Projects: 61

1. If a behavior change communication (BCC) component was planned, list the summary of ESTIMATED BCC costs as a percentage of project expenditure [based on appraisal data].

46% (22 projects) provided information on estimated BCC costs. The average estimated cost was $2.19 million

2. If a BCC component was specified, list the summary of ACTUAL BCC costs as percentage of project expenditure.

53% (25 projects) provided information on actual BCC costs. The average actual cost $1.82 million

3. If the project attempted to increase demand for HNP interventions did the project undertake:

27% (13 projects) Formative research to prepare BCC materials
6% (3 projects) Assessment of BCC impact
15% (7 projects) Client/beneficiary feedback of BCC

4. If the project attempted to build consensus, please specify the methods used.

11% (5 projects) specified the methods; these projects are discussed in the main text of the study.

5. If a BCC component was planned, please rate the level of execution.

60% (29 projects) Implemented and Satisfactory
23% (11 projects) Implemented and Partially Satisfactory
15% (7 projects) Implemented with Delay or Difficulty
2% (1 project) Planned but Not Implemented

6. Describe the BCC activities completed (for a full list of activities see Annex 1)

Mass media campaigns (radio, TV, newspaper), popular or folk media campaigns (theater, dance), social marketing, community mobilization, education, women’s literacy groups, and various advocacy efforts.

7. If the project had indicators to measure BCC inputs, what progress has been made toward reaching the established targets?

13% (6 projects) Substantial progress achieved
17% (8 projects) Partial progress achieved
2% (1 project) Negligible progress achieved
69% (33 projects) No data in ICR
8. If the project had indicators to measure BCC outputs (e.g. number of people reached by IEC campaign or number of television programs/radio spots aired) what progress has been made toward reaching the established targets?

- 35% (17 projects) Substantial progress achieved.
- 17% (8 projects) Partial progress achieved
- 13% (6 projects) Negligible progress achieved.
- 35% (17 projects) No data in ICR

9. If the project had indicators to measure BCC impact on health behaviors what progress has been made toward reaching the established targets?

- 25% (12 projects) Substantial impact. Program meeting expectations
- 10% (5 projects) Partial. Some BCC activities have had the desired impact while others have not.
- 10% (5 projects) Negligible impact. Project failed, failing or no impact.
- 54% (26 projects) No data in ICR

10. Did the responsible agency possess the capacity necessary to implement the planned BCC activities?

- 25% (12 projects) No
- 40% (19 projects) Yes with support provided under the project
- 17% (8 projects) Yes without support provided under the project
- 19% (9 projects) No data in ICR

11. If project implementation involved collaboration between multiple governmental and/or non-governmental agencies, was this collaboration successful?

- 42% (20 projects) Successful
- 27% (13 projects) Moderately successful
- 15% (7 projects) Unsuccessful. Partners failed to collaborate and as a result project objectives were not met.
- 17% (8 projects) No data in ICR

12. How successful was Bank supervision of the BCC component?

- 13% (6 projects) Fully supported by supervision
- 27% (13 projects) Some input from staff or Bank consultants who are BCC specialists.
- 31% (15 projects) Minimal input from staff or Bank consultants, usually non-BCC specialists
- 6% (3 projects) No input from staff or Bank consultants
- 23% (11 projects) No data in ICR

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16 All percentages have been rounded to whole numbers.
17 22 projects with BCC cost estimate data divided by 48 projects with a planned BCC component = 46%
18 25 projects with BCC actual cost data divided by 47 projects with an implemented BCC component =
Annex 3

Selected Resources for Strategic Communication

World Bank: Communications Network
CommNet is an association of communications professionals across the World Bank Group. The network develops the training curriculum and maintains an intranet knowledge management system called CommRAD, through which all members can share best practices in strategic communication.

World Bank: Development Communications Division (DevComm), External Affairs Vice-Presidency
http://www.worldbank.org/developmentcommunications
DevComm supports the Bank’s mission of reducing poverty by providing strategic communication advice and tools needed to develop and implement successful projects and reform efforts. DevComm’s Strategic Communication Learning Program designs, develops, and delivers face-to-face, distance learning, and e-learning courses and workshops in communication to Bank staff and client country counterparts. The DevComm Reader is a period issue on communication, which serves as a forum for the Bank’s communication practitioners and operational staff to share ideas and best practices on how to integrate communication in development projects.

Communications Initiative:
www.comminit.com
The Communication Initiative is a partnership of development organizations seeking to support advances in the effectiveness and scale of communication interventions for positive international development. Website covers case studies, research and organizations working in a wide range of sectors and regions.

Health Communications Partnership:
http://www.hcpartnership.org/
The Health Communications Partnership (HCP) is a new online resource for those interested in improving health communications. HCP is supported by USAID, and includes Johns Hopkins School of Public Health/Center for Communication Programs, the Academy for Educational Development, Save the Children, The International HIV/AIDS Alliance and Tulane University’s School of Public Health and Tropical Medicine. HCP links these five institutions together to accomplish its goal of strengthening public health in the developing world through strategic communication programs. HCP and its partners work to create an environment that supports individuals, families, and communities to act positively for their own health and to advocate for and have access to quality services.

John Hopkins University Center for Communication Programs:
http://www.jhuccp.org/
Focuses on communications for public health projects

UNESCO: Communications and Information Program
UNESCO’s development communication programs follow three objectives: 1) promotes the free flow of ideas and universal access to information 2) the expression of pluralism and cultural diversity in the media and world information networks. 3) access for all to ICTs.
FAO: Communications for Development Program
FAO’s Sustainable Development Department has been a pioneer in the use of communication processes and media to help rural people to exchange experiences, find common ground for collaboration and actively participate in and manage agricultural and rural development activities.

Rockefeller Foundation: Communications for Social Change Program
http://www.rockfound.org/display.asp?Context=3&SectionTypeID=25&Preview=0&ARCurent=1
Communications for social change enhances the effectiveness of development initiatives by fostering a process where “community dialogue” and “collective action” work together to produce social change in a community that improves the health and welfare of all of its members. Case studies and research provided.

One World Radio
http://radio.oneworld.net/index.php?
Offers services and networking for broadcasters and civil society organizations who are using radio for human rights, sustainable development and democracy. This site provides examples of how CSO’s are using broadcasting to advocate their development agenda.

World Summit on the Information Society
www.itu.int/wsis/index.html
The First Phase of the World Summit on the Information Society took place in Geneva from 10 to 12 December 2003. It addressed the broad range of themes concerning the Information Society and adopted a Declaration of Principles and Plan of Action.

Annenberg School of Communications, University of Pennsylvania
www.asc.upenn.edu
Provides research on communications for reforms in diverse sectors, studies of several constituencies and a journal.
Background

In 1998, the World Bank approved a credit of US $34 million to the Republic of Uganda to support the government’s National Program of Action for Children, whose goal is to improve the health, nutritional, and cognitive and psychosocial development of preschool children. The project’s approach was to strengthen the ability of parents and communities to care for their children by providing them with knowledge on better childcare practices and by increasing their opportunities to earn income.

A package of linked services was provided at the community level. These services were delivered mainly by NGOs, hired on a competitive basis and working as change agents in collaboration with district governments and with community-based organizations. The project’s three main components were:

An integrated childcare package that draws both on local experience and on global best practices. The project mobilized groups of parents and surrogate parents at the community level, facilitated by animateurs from the locality and supported by the project with materials, technical supervision, and communications. Activities included inculcation of good childcare practices, growth monitoring and promotion, nutrition counseling, and pre- and post-natal care for mothers and babies. To help build up the capacity of communities for childcare, the project sponsored planning and sensitization workshops and “child fairs”. Each child fair involved 12 villages converging and sharing information. There are competitions, counseling, weighing of children, immunizations and cooking demonstrations. The educational messages promoted through the child fairs are reinforced by mass communications, including radio talk shows, as well as street theater. To help women form savings groups and skills for micro-enterprises that generate income, they received training in savings, basic accounting and management skills.

Community support grants and an innovation fund. Helped by NGOs, communities assessed their needs, propose activities, and got grants to support micro-projects that will benefit young children. Examples include projects to produce appropriate weaning foods, and community- and home-based childcare centers. For their part, communities contributed goods, works, or services. NGOs provided technical supervision and training.

National support program for child development. This component supported participatory monitoring and evaluation activities; activities to promote the use of micronutrients; and ECD curriculum development for preschool teachers. Several of these activities involved working closely with WHO, UNICEF, and the private sector.

Targeting

Over its five-year lifecycle the project was expected to cover 8,000 communities in 20 of Uganda’s 39 districts. Districts were chosen
on the basis of levels of malnutrition, infant mortality, and primary school enrollment rates. After five years, the Government hopes to extend the project’s approach to the rest of the country.

**Expected Outcomes**

The project sought to:

- halve the prevalence of malnutrition among pre-school children in the project areas by the end of the project, increasing readiness of this cohort of children for school, and supporting the drive for universal primary education;
- raise enrollment in primary schools and reduce dropout and repetition rates;
- improve psycho-social and cognitive development; and
- double the proportion of mothers practicing appropriate childcare, from one in four to one in two.

The hope is that early childhood development will ultimately pay for itself by reducing the costs of having children drop out and repeat grades.

**Communication Objectives**

The project’s communication component aimed to increase parents’ knowledge about childcare and promote changes in attitudes and behaviors in ways that will enhance the nutritional status and psychosocial and cognitive development of preschoolers.

**Communication Strategy**

The communication strategy was developed based on research and analysis of the following five issues:

- Whose support is critical to the success of this project?
- What changes in knowledge, attitudes, and behaviors will need to occur among various groups?
- What messages will be persuasive to these groups?
- What channels of communication will reach these groups effectively?
- How do we evaluate the success of communication activities?

A series of communication planning workshops (December 1996, June 1997, August 2000) were conducted with the government’s project preparation unit/project implementation unit and their collaborating partners from international and national NGOs, faith-based organizations, community-based groups, local government officials, and representatives of donor agencies. In addition, two groups participated in a six-week distance-learning course on Strategic Communication for Development Projects held in 2000 and 2001. Course participants presented the communication strategy for the Uganda NECD project to co-participants from other Anglophone African countries as part of the coursework.

The communication strategy included both upstream and downstream communication activities. Upstream communication aimed to strengthen understanding and buy-in from key constituencies—members of Parliament, media, international NGOs and donor agencies—active in Uganda’s development programs, faith-based organizations, and community-based groups. Downstream communication activities refer to the communication component of the Nutrition and ECD project aimed at helping parents to learn about and adopt new childcare practices.

**Implementation**

**Building support and buy-in**

The Minister of Finance, Planning and Economic Development, who led project preparation, had foreseen the value of building alliances within Parliament and created a Parliamentary Advocacy Committee. Members of the Advocacy
Committee participated in a communication planning workshop. At this workshop Parliamentarians were also given on-camera training to provide real-time and hands-on practice on how to communicate to media and other stakeholders about the project.

As the project got underway, key members of Parliament were also invited to visit Kenya’s Early Childhood Development project as a way of gaining information on what makes ECD projects successful. Throughout project implementation, Parliamentarians were given updates on the status of communication activities and feedback from the field. Audiotapes of key messages about the project were given to Parliamentarians to enable them to keep abreast of project activities.

Likewise, media professionals were actively engaged in reporting on the project. Media representatives were invited to participate in various communication planning sessions, including attendance at the distance-learning course on Strategic Communication for Development Projects mentioned above.

Teaching parents new childcare practices

Communication activities targeted three childcare practices, namely: hygiene and sanitation (including de-worming); complementary feeding; and positive parental interaction.

Communication research was undertaken to understand parents’ perception of proper childrearing and to identify perceived “costs” and benefits of adopting new practices promoted by the project. Furthermore, the study identified opportunities for parent-child interaction. Through communication research the team discovered that current perceptions about proper childrearing were often at odds with the new childcare concepts of encouraging the child to be active, inquisitive, and to explore his/her immediate environment. For example, parents’ concept of a “good” two-year old was “one who is obedient, polite, respectful, one who does not ask for food all the time but likes to eat, and does not cry”. The “bad” two-year-old was described as “one who cries unnecessarily and wants to be held frequently, fights with other children, is disrespectful, disobedient, ill-mannered, and destructive.”

Results

Building support and buy-in

On August 13, 1998, Parliament approved the Government’s plan to accept World Bank financing for the Nutrition and Early Childhood Development project. However, Parliamentary support was not readily apparent for three months prior to approval as Parliamentarians had heated debates on whether it was in Uganda’s interest to accept a loan for such a project. Mass media kept the issue alive and controversial in the press and on radio broadcasts.

Building alliances through the Parliamentary Advocacy Committee was invaluable in securing Parliamentary approval of the project. Continuing to involve Parliamentarians by providing them an opportunity to observe the activities of the Kenya Early Childhood Development (ECD) project in May 1999 also helped increase understanding of the nature of ECD activities, the project management structure, and policy framework.

Teaching parents new childcare practices

Following are some highlights on results of communication activities. These describe levels of knowledge, and adoption of new attitudes and behaviors after several months of advocacy regarding the importance of nutrition and early child development for Uganda’s future. The data are presented for two points in time—Time 1 refers to September 2001, but is not a baseline measure, and Time 2 refers to September 2002. These results come from individual household surveys conducted with mothers who are the primary caretakers of young children.
At Time 1 42% of mothers had heard about the project’s messages about the importance of de-worming children. A year after, 53% of mothers recalled having heard the project’s message about de-worming.

The project provided specific messages about the importance of early childhood development. One such message was that “young children learn through play.” At Time 1, 34% of mothers reported hearing about this message. By Time 2, this had increased to 50%.
The project was also interested in assessing whether mother’s attitudes about early childhood development changed over time. Data revealed that at Time 1, 38% of mothers reported that ECD practice “increases the child’s self-esteem.” This positive attitude continued to increase, and at Time 2, 46% of mothers reported such attitude.

Another attitude statement made by mothers was that ECD “promotes the child’s communication skills.” At Time 1, 28% of mothers reported such an attitude. At Time 2, 47% of mothers reported this positive attitude.
Mothers also reported a positive attitude about the value of play to the child’s development (this was one message given by the project). At Time 1, 30% of mothers reported this positive predisposition with regards this message; at Time 2, 44% of mothers reported a positive attitude about the value of play to the child’s development.

In terms of behavior change, de-worming showed a clear increase. At Time 1, 48% reported having had the child de-wormed. At time 2, 59% reported having de-wormed the child. Further data showed that 60% of the children who received de-worming medicines and who lived in communities where the medicine was provided, received it at the Child Fairs organized by the project.